Calendar No. 123

101ST CONGRESS *1st Session*	SENATE	REPORT 101-51

CHILD CARE AND HEALTH INSURANCE ACT OF 1989

REPORT

OF THE

COMMITTEE ON FINANCE UNITED STATES SENATE

TO ACCOMPANY

S. 1185

JUNE 14 (legislative day, JANUARY 3), 1989.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
29-010 WASHINGTON : 1989

S363-2

CONTENTS

	Page
I. Summary and legislative background	2
A. Summary	2
B. Legislative background	4
II. Explanation of the bill	5
A. Tax credit for child care and certain health insurance premiums	5
B. One-year delay and simplification of section 89 nondiscrimination rules applicable to certain employee benefit plans	12
C. Extension of the telephone excise tax	34
D. Estimated tax payment requirement of S. 1185 corporations	36
III. Budget effects	38
IV. Regulatory impact and other matters to be discussed under Senate rules	40
A. Regulatory impact	40
B. Other matters	41
V. Changes in existing law made by the bill	41

Calendar No. 123

101ST CONGRESS
1st Session

SENATE

REPORT
101-51

CHILD CARE AND HEALTH INSURANCE ACT OF 1989

JUNE 14 (legislative day, JANUARY 3), 1989.—Ordered to be printed

---

Mr. BENTSEN, from the Committee on Finance, submitted the following

REPORT

[To accompany S. 1185]

The Committee on Finance, to which was referred the bill (S. 1185) to amend the Internal Revenue Code of 1986 to allow a credit for health insurance premium costs, to make the dependent care credit refundable, to simplify the anti-discrimination rules applicable to certain employee benefit plans, and for other purposes, having considered the same, reports favorably thereon without amendments, and recommends that the bill do pass.

I. SUMMARY AND LEGISLATIVE BACKGROUND

A. SUMMARY

Tax Credit for Child Care and Certain Health Insurance Premiums

Present law permits taxpayers to claim a nonrefundable tax credit equal to a percentage of the employment-related child or dependent care expenses paid by the individual for a taxable year. The maximum amount of the credit is 30 percent of allowable expenses in the case of a taxpayer with adjusted gross income (AGI) of $10,000 or less.

The bill makes the present-law dependent care credit refundable in the case of taxpayers with AGI not in excess of $28,000. The credit is 33-1/3 percent refundable for taxable years beginning in 1990. In addition, the bill increases the dependent care credit to 34 percent for taxpayers with AGI of less than $8,000 and to 32 percent for taxpayers with AGI of at least $8,000, but less than $10,000.

The bill amends the present-law dependent care credit to add a new refundable credit for health insurance expenses if such expenses include amounts paid for coverage of a dependent child of the taxpayer who is under the age of 19. The maximum credit is 50 percent of the qualified health insurance expenses, reduced by 5 percentage points for each $1,000 (or fraction thereof) by which the taxpayer's AGI exceeds $12,000. Up to $1,000 of qualified health insurance expenses may be taken into account in calculating the credit.

Further, the bill (1) authorizes the establishment of demonstration projects to evaluate and extend health insurance to children under age 19 who are not covered by other public or private health programs and (2) directs the GAO, in consultation with the IRS, to conduct a study of the effectiveness of an advance payment system for refundability and how to implement such a system to avoid administrative complexity for small business.

One-Year Delay and Simplification of Section 89 Nondiscrimination Rules Applicable to Certain Employee Benefit Plans

Under present law, health plans and group-term life insurance plans are subject to nondiscrimination rules under section 89 of the Code. An employer may also elect to test its dependent care assistance programs under section 89 in lieu of applying the nondiscrimination rules contained in section 129 that otherwise apply to such plans. These plans, as well as certain other fringe benefit plans, must also meet minimum qualification requirements (e.g., the plan must be in writing, enforceable, etc.).

If the employer does not meet the nondiscrimination rules, then all or a portion of the coverage provided under the plans is included in the taxable income of highly compensated employees. If the qualification rules are not met then the benefits received (e.g., reimbursements) under the plan are taxable.

Under the bill, new nondiscrimination rules and modified qualification rules are delayed for one year and are effective for plan years beginning after December 31, 1989. With respect to health

plans, the bill repeals the present-law nondiscrimination rules and replaces them with a simplified test. In general, if coverage is to be tax-favored with respect to highly compensated employees, the employer must make affordable coverage available to 90 percent of its employees. Further, no highly compensated employee may receive tax-favored coverage that is in excess of 133 percent of the value of the coverage that is available to 90 percent of the employees.

The bill also makes several changes with respect to the nondiscrimination rules, including rules relating to those employees who may be disregarded in determining whether an employer meets the new 90-percent eligibility test. Among these changes is a new definition of leased employees and a modification of the definition of part-time employees. Under the latter change, the employer may disregard those employees normally working less than 30 hours per week.

Finally, the bill modifies the sanction relating to the qualification rules by imposing an excise tax on an employer that fails to correct a failure to comply.

Extension of Telephone Excise Tax

The current 3-percent telephone excise tax is scheduled to expire after December 31, 1990. The bill permanently extends the 3-percent telephone tax.

Also, the bill modifies the current schedule for deposit of the telephone excise tax. The bill provides that the telephone excise tax billed for a semi-monthly period is to be deposited within 3 banking days after the first week following the next semi-monthly period. This change in the deposit requirement is effective for tax billed after August 15, 1990.

Further, the bill provides that certain organizations exempt from the tax no longer have to file a certificate of exemptions annually.

Estimated Tax Payment Requirements of S Corporations

Under present law, S corporations are subject to tax at the entity level with respect to certain items. However, S corporations are not required to make estimated tax payments with respect to such liabilities.

The bill requires an S corporation to make estimated tax payments if it has tax attributable to (1) the recognition of certain built-in gains (sec. 1374(a)), (2) the realization of excess passive income (sec.1375(a)), and (3) the recapture of certain investment tax credits (sec. 1371(d)).

The provision is generally effective for estimated tax payments due after the date of enactment.

B. Legislative Background

The Committee on Finance held a public hearing on June 12, 1989, on tax proposals relating to (1) tax credit for child care and certain health insurance premiums, (2) simplification of section 89 nondiscrimination rules applicable to certain employee benefit plans (S. 1129), (3) extension of the telephone excise tax, and (4) estimated tax payment requirements of S corporations.

The Committee on Finance held a markup session on these tax proposals on June 13, 1989, and ordered the provisions as amended favorably reported by a roll call vote of 17 ayes and 3 noes.

II. EXPLANATION OF THE BILL

A. Tax Credit for Child Care and Certain Health Insurance Premiums (Title I of the Bill)

Present Law

Child and dependent care credit

Under present law, an individual who maintains a household that includes one or more qualifying individuals is entitled to a nonrefundable tax credit equal to a percentage of the employment-related child or dependent care expenses paid by the individual for the taxable year to enable the individual to work (sec. 21). The maximum amount of the credit is 30 percent of allowable employment-related expenses. This 30 percent is reduced by one percentage point for each $2,000 (or fraction thereof) of the taxpayer's adjusted gross income (AGI) between $10,000 and $28,000. The credit rate is 20 percent for taxpayers with AGI in excess of $28,000.

The maximum amount of expenses that may be taken into account in calculating the credit is limited to $2,400 per year in the case of one qualifying individual and $4,800 in the case of more than one qualifying individual. In addition, the maximum amount of expenses taken into account cannot exceed the individual's earned income or, in the case of married taxpayers, the lesser of the individual's earned income or the earned income of his or her spouse. A special rule applies for determining the income of the taxpayer's spouse if the spouse is a full-time student or mentally or physically incapable of caring for himself or herself.

A "qualifying individual" is (1) a dependent of the taxpayer who is under the age of 13 and with respect to whom the taxpayer is entitled to claim a dependent exemption, (2) a dependent of the taxpayer who is physically or mentally incapable of caring for himself or herself, or (3) the spouse of the taxpayer, if the spouse is physically or mentally incapable of caring for himself or herself.

Tax provisions relating to individual health insurance

Present law generally does not provide tax benefits specifically designed to encourage the purchase of health insurance by individuals; however, present law does provide certain tax benefits for health insurance in particular circumstances.

Under present law, health insurance that is paid by an employer is generally excluded from an employee's gross income. This exclusion also applies for employment tax purposes. In addition, self-employed individuals are entitled to deduct 25 percent of the amount paid for medical insurance for the individual or his or her spouse or dependents; this provision is scheduled to expire for taxable years beginning after December 31, 1989. These provisions are subject to the application of nondiscrimination rules and certain other requirements.

Taxpayers who itemize deductions may deduct expenses for medical care (not compensated by insurance or otherwise) of the taxpayer or his or her spouse or dependents to the extent such expenses exceed 7.5 percent of the taxpayer's adjusted gross income. Premiums paid for health insurance qualify for the deduction.

Reasons for Change

In general

The committee's bill is aimed at meeting two major needs of low-income working families—health insurance coverage to protect both children and parents and child care. When fully phased in, the bill will provide nearly $1-1/2 billion a year to help parents pay for health insurance, and it provides an even larger amount, increasing over time, to help working parents meet the costs of child care. Although these expenditures are substantial sums in a time of fiscal restraint, they will be spent in areas of urgent need, and most of the benefit will go to low-income families.

The committee recognizes that there are millions of low-income American families who are struggling to insure the well-being of their children. They are working and contributing to the Nation's economy. But their wages are simply not sufficient to meet today's high costs of health insurance and child care. What this bill offers is an effective way to help with these two high priority needs. It constitutes a carefully targeted response to the complex needs of low-income Americans for health protection and for child care.

The bill is designed to complement Federal, State and local programs created to encourage the direct provision of child care services for low-income families. With respect to child health, the committee's bill will complement Federal and State efforts to strengthen the scope and effectiveness of the Medicaid and Maternal and Child Health programs. The committee expects to be working on additional strategies to improve these programs in the near future.

But there are millions of low-income families throughout the country who, by reason of income or other eligibility criteria, do not qualify for the support offered by Medicaid, the Maternal and Child Health Block Grant, or other public service programs, and they need help, too. A credit for health insurance expenditures will help these families meet the cost of private health insurance premiums. What the committee is proposing is a new, but complementary strategy to meet the diverse needs of low-income working families.

The committee recognizes that the credits provided by this bill do not come close to meeting all the needs of the working poor for health care and child care. They are a first step, and in the area of health care, one that the committee believes holds particular promise. The bill challenges the States, insurers, and public and private organizations of all kinds to come up with new policy alternatives to meet the health needs of children.

The committee's bill greatly improves the equity and availability of the current dependent care credit for low-income working families in three ways.

First, it creates a new credit to cover expenditures for health insurance policies that include children. Families will not have to choose between the health insurance and child care credits. They will be eligible for both.

Second, it makes the existing dependent care credit refundable, thereby enabling families with incomes below the Federal income tax threshold to use it for the first time.

Third, the bill increases the maximum rate of the credit for child care for families with very low income. Currently, the maximum credit is 30 percent of allowable child care expenditures for families with incomes below $10,000. This maximum would be increased to 32 percent for families with incomes from $8,000 to $10,000, and to 34 percent for families with incomes below $8,000.

In addition, the bill authorizes $25 million a year for five years in new demonstration funds to encourage public and private nonprofit institutions, such as school systems, nonprofit organizations offering health insurance, or hospitals, to develop innovative ways to provide affordable health insurance and other forms of health coverage to children and their families.

By making the dependent care tax credit refundable, the bill gives low-income families who need child care in order to work a substantial new source of assistance in meeting the costs of that care. Families in which one parent chooses not to work will also receive significant assistance in meeting the costs of health insurance protection for their children and themselves.

Child health insurance credit

The new refundable child health insurance credit is targeted solely at working families with children with adjusted gross income not in excess of $21,000. This credit will be of direct and immediate assistance to help these families meet the high cost of monthly premiums. Beginning in 1992, employees will be allowed to take the credit in the form of an addition to their regular paychecks, so it will be available when it is needed.

The committee notes that at the present time there are 13 million children, or nearly one in five, without any public or private health care coverage. Nearly two-thirds of these children are in families with incomes below 185 percent of the poverty level. The chance of being uninsured is 37 percent higher for a child than for an adult.

The committee believes that the health insurance credit will result in increased health coverage for low-income children. There will be a clear economic incentive for families to purchase insurance, and there will be an incentive for insurers to provide it. The committee also expects States and other public and private institutions to respond by putting together affordable insurance packages for children in ways that begin to get at the problem of the lack of health insurance protection for children.

At recent hearings held by the committee on the subject of the health insurance credit, insurers testified to the effect that the credit will improve health insurance coverage of low-income children. The committee believes that only by developing a constructive public-private partnership will this nation be able to assure the availability of health insurance to all children who need it.

The committee also heard testimony concerning new and innovative strategies to bring health insurance within the reach of all American children. For example, a school-based insurance program is being developed on a demonstration basis in the State of Florida. This program will be available to all uninsured children and to their parents and siblings, on a subsidized, sliding scale basis.

It is expected that some small businesses will buy into the school-based program for their employees, taking advantage of large group size so as to reduce the cost of their premiums. The insurance will be portable, with the only requirement being that the child remain within the covered school districts. It has been suggested that one "fringe benefit" of the program might be to provide students with an incentive for staying in school so as not to lose health insurance coverage for themselves and their families.

Refundable child care tax credit

Today there are more than 11 million pre-school children with mothers in the labor force, and if present trends continue, there may be nearly 15 million young children with mothers in the labor force by 1995. Nearly half of these young children are cared for by a member of the family, and cost is ordinarily not a factor. But millions of children throughout the Nation are being cared for in a child care center or in a family day care home, where the cost of full-time care for one child typically comes to about $3000 a year or more. Costs such as these constitute a very heavy burden on low-income families.

The committee heard testimony that while high-income families typically spend under 5 percent of their budget on child care, families with low income spend very much more, as much as 20-26 percent of their budget for child care services.

At the present time, the dependent care credit provides significant child care assistance to middle and higher income families. This year, according to the Joint Committee on Taxation, the nearly 8-1/2 million families who use the credit will receive about $3.7 billion to assist them in meeting the costs of child care. But families with little or no income tax liability receive little or no benefit from this credit.

Under the committee's bill, a substantial portion of the new child care money that will be claimed under the refundable credit will go to families with incomes so low they are below the Federal tax threshold. Those who are better off will still receive the subsidy they are entitled to under present law. The amount of their credit will not be changed in any way. But on balance, the fundamental fairness of the credit will be greatly improved.

The committee's bill builds on last year's successful efforts to improve the availability of child care and medical services to millions of our poorest children and their families.

The passage last fall of legislation to reform the American welfare system marked a major turning point in national policy with respect to helping those in greatest need, families on welfare. That legislation emphasizes education and training for welfare parents, to help them join the Nation's work force, and bring their families into the mainstream of American life. As part of that legislation, the Congress provided extended child care and Medicaid benefits so that parents could make the transition from welfare to work without jeopardizing the welfare of their children.

The bill which the committee is reporting recognizes the fact that there are many more millions of American families with incomes above the welfare or Medicaid eligibility level who find themselves without adequate resources to provide their children

with necessary child care and basic health protection. This bill will help to fill that gap.

The committee believes it is time to more one step further along the way toward helping working poor families meet their basic needs for health care protection and for child care. The bill which the committee has approved holds out promise for real progress in the years to come.

Explanation of Provisions

The bill makes the present-law dependent care credit refundable for certain taxpayers, increases and modifies the dependent care credit, and allows an additional credit for expenditures for certain health insurance policies.

Health insurance credit

The bill amends the dependent care credit to add a new refundable credit for health insurance expenses. The bill provides that an individual who maintains a household containing one or more qualifying individuals is entitled to a credit equal to a percentage of the individual's qualified health insurance expenses. The maximum credit percentage is 50 percent of the qualified health insurance expenses. This 50 percent is reduced by 5 percentage points for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income (AGI) exceeds $12,000. Thus, the credit is zero for taxpayers with AGI in excess of $21,000.

Qualified health insurance expenses are amounts paid during the taxable year for health insurance that includes coverage for one or more qualifying individuals. For purposes of this credit, a qualifying individual is a dependent of the taxpayer who is under age 19 and with respect to whom the taxpayer can claim a dependent exemption.

Up to $1,000 of qualified health insurance expenses may be taken into account in calculating the credit. However, the maximum expenses taken into account cannot exceed the earned income of the taxpayer, reduced by employment-related expenses taken into account in determining the child care credit. Expenses, to the extent paid, reimbursed, or subsidized by the Federal government or a State or local government, are not eligible for the credit.

Eligible taxpayers may claim both the dependent care credit and the health insurance credit.

For taxable years beginning after December 31, 1991, the health insurance credit will be refundable on an advance payment basis (similar to the present-law earned income credit).

Refundable dependent care credit

The bill makes the present-law dependent care credit refundable. That is, taxpayers who do not have sufficient taxable income to offset the credit will be entitled to receive the amount of the credit not offset against tax liability in cash. However, under the provision, taxpayers with adjusted gross income (AGI) in excess of $28,000 are not entitled to claim the refundable credit, but instead are eligible for the nonrefundable dependent care credit as under present law.

For taxable years beginning in 1990, the dependent care credit will be 33-1/3 percent refundable. For purposes of determining the amounts of credit that are refundable and nonrefundable, other credits and deductions are applied before the dependent care credit, except for the earned income tax credit which is applied after the dependent care credit.

For example, suppose a taxpayer has tax liability of $70 after the application of all credits and deductions except the dependent care tax credit and the earned income tax credit, $100 of dependent care credit (before the refundability limitation), and $150 of earned income tax credit. The taxpayer offsets $70 of tax liability with $70 of the dependent care tax credit. Of the remaining $30 of dependent care credit, $10 may be obtained as a refund while all of the $150 of earned income credit is refundable.

For taxable years beginning after December 31, 1990, the dependent care credit will be fully refundable. For taxable years beginning after December 31, 1991, the dependent care credit will be refundable on an advance payment basis (similar to the present-law earned income credit).

Increase percentage of dependent care credit

The bill increases the dependent care credit to 34 percent for taxpayers with AGI less than $8,000 and to 32 percent for taxpayers with AGI of at least $8,000 but less than $10,000. For taxpayers with AGI of at least $10,000, the credit rate will be the same as the present-law rate.

Expenses, to the extent paid, reimbursed, or subsidized by the Federal government or a State or local government, are not eligible for the credit. For example, child care expenses that are disregarded for purposes of calculating payments under the Aid to Families with Dependent Children Program which would otherwise have reduced payments under such program and expenses reimbursed under the transitional child care assistance program of the Family Support Act of 1988 are not expenses eligible for the credit.

The committee expects that the Secretary of the Treasury will provide regulations to prevent abuse of the dependent care tax credit. The committee, for example, does not intend the dependent care credit to be available in certain reciprocal dependent care arrangements that do not enable gainful employment beyond the child care arrangement.

For example, assume two neighbors agree to pay each other to care for the other's children and the child care expenses incurred by each neighbor do not enable each individual to be gainfully employed in some manner aside from providing care to the neighbor's children. In such a case, the committee does not intend the expenses to be eligible for the credit.

However, the committee does not intend to prevent individuals otherwise legitimately employed as dependent care providers from obtaining the credit on eligible dependent care expenses.

Child health demonstration projects

The bill authorizes the appropriation of $25 million for each of the fiscal years 1990 through 1994 to enable the Secretary of Health and Human Services to conduct demonstration projects to

evaluate and extend health insurance to children under age 19 who are not covered by other public or private health programs.

The Secretary is authorized to enter into agreements with public and private organizations (for example, schools and hospitals) to provide health insurance coverage to such children. The Federal government is to share up to 50 percent of the cost of programs under such agreements.

The health care program provided by an organization pursuant to such an agreement cannot restrict enrollment on the basis of a child's medical condition or impose waiting periods or exclusions for preexisting conditions. The program can also cover the parents of the child. The Secretary may permit the organization to charge for the health care.

The Secretary is directed to publish criteria governing the eligibility and participation of organizations in the demonstration projects by January 1, 1990.

GAO Study/IRS Information Program

The General Accounting Office (GAO), in consultation with the Internal Revenue Service (IRS), under the provision, is required to conduct a study to determine (1) the effectiveness of the advance payment system and (2) how to implement such a system to avoid administrative complexity for small business. A report to the Committee on Finance and the Committee on Ways and Means with recommendations is required within one year after enactment.

The IRS is required to undertake efforts to inform the public of the availability of the credit in order to assure that persons who may be eligible will know the requirements for receiving the credit and how to apply for it.

Effective Dates

The refundability feature and the modifications to the present-law dependent care credit generally are effective with respect to taxable years beginning after December 31, 1989. The health insurance credit generally is effective for taxable years beginning after December 31, 1990.

Revenue Effect

The provision relating to the expansion and refundability of the child care credit is estimated to reduce fiscal year budget receipts by $25 million in 1990, $565 million in 1991, $1,763 million in 1992, $1,832 million in 1993, and $2,000 million in 1994.

The provision relating to the child health insurance credit is estimated to reduce fiscal year budget receipts by $70 million in 1991, $1,473 million in 1992, $1,385 million in 1993, and $1,368 million in 1994.

The above estimates include the outlay effects of making the credits refundable. (See Part III, Budget Effects, for specific outlay amounts for the refundable portion of the child care and health insurance credits.)

B. One-Year Delay and Simplification of Section 89 Nondiscrimination Rules Applicable to Certain Employee Benefit Plans (Title II of the Bill)

Present Law

Overview

As enacted by the Tax Reform Act of 1986 and amended by the Technical and Miscellaneous Revenue Act of 1988, Code section 89 has two basic sets of requirements: (1) nondiscrimination rules; and (2) plan qualification requirements. In general, the nondiscrimination rules measure the extent to which health benefits (and certain other types of fringe benefits) are made available to rank-and-file employees and the extent to which such employees actually receive those benefits. These rules basically require an employer to compare benefits provided to highly compensated employees with benefits provided to the rank-and-file employees. These rules are designed to limit tax-favored treatment of employee benefits unless a significant portion of such benefits are provided to rank-and-file employees.

The qualification requirements require health plans (and certain other types of fringe benefit plans) to satisfy certain minimum basic requirements, for example, that the plan be in writing and be legally enforceable.

Nondiscrimination rules

Plans subject to the nondiscrimination rules

In general, health plans and group-term life insurance plans are subject to the section 89 nondiscrimination rules. An employer may also elect to test its dependent care assistance programs under section 89 in lieu of applying the nondiscrimination rules contained in section 129 that otherwise apply to such plans. Disability benefits are subject to the rules to the extent the benefits are excludable from income under section 105(b) or (c) of the Code. Benefits provided under nonhealth plans may not be taken into account in determining whether the employer's health plans satisfy the nondiscrimination rules.

All employer-provided health coverage is taken into account under section 89. For example, plans providing medical diagnostic procedures or physical examinations are health plans subject to section 89. Health coverage is required to be taken into account under section 89 regardless of the method by which it is provided, for example, through an insurance plan, a self-insured arrangement, or a voluntary employees' beneficiary association (VEBA).

Plans providing for short- and long-term disability benefits, wage continuation benefits, and workers compensation benefits generally are not subject to the section 89 nondiscrimination rules. Similarly, vacation pay plans of the employer are not subject to the section 89 nondiscrimination rules.

The nondiscrimination rules apply to plans maintained by all types of employers, other than plans maintained by churches and certain church-controlled organizations. Thus, section 89 applies to plans of small and large employers, taxable and tax-exempt em-

ployers, private and public employers (including the Federal Government), and plans maintained by more than one employer (i.e., multiple employer and multiemployer plans).

Nondiscrimination tests

There are two methods by which an employer may test its plans to determine compliance with section 89: (1) a four-part testing method, and (2) an alternative, simplified two-part testing method. The employer may choose either testing method, and only needs to use one method, even if use of the other method might lead to different results under section 89.

Four requirements must be met under the 4-part test. First, at least half of the employees eligible to participate in the plan must be rank and file employees. This test is designed to limit the tax-favored treatment of plans primarily covering highly compensated employees (e.g., executive-only plans).

The second requirement is that at least 90 percent of the rank and file employees must have available to them a benefit at least half as valuable as the most valuable benefit available to any highly compensated employee. This test is designed to ensure that a significant percentage of rank and file employees have a minimum benefit available to them. For example, if the highest benefit available to any highly compensated employee is worth $1,000, then to pass this test, 90 percent of the rank and file employees must have available a benefit of at least $500.

The third requirement is that the value of coverage received by rank and file employees must be at least 75 percent of the average value of coverage received by highly compensated employees. This test is designed to ensure that rank and file employees actually receive a significant portion of the tax benefits spent for health coverage.

Finally, under the 4-part test, the plan may not contain any provision relating to eligibility to participate that discriminates in favor of highly compensated employees (the nondiscriminatory provisions test). This is a subjective test and is intended to be applied in situations that are not measured by the numerical tests, for example, where coverage for a rare disease is theoretically provided to all employees but in fact only the company president can benefit from the coverage. This test also applies to the method by which the employer tests.

Under the 2-part test, the following requirements must be satisfied. First, at least 80 percent of the employer's rank and file employees must be covered by the plan (or group of aggregated plans). This test was designed primarily for small employers.

The second requirement under the 2-part test is that the plan must satisfy the nondiscriminatory provisions test. This is the same test that is described above.

Salary reduction contributions

Under present law, special rules apply to pre-tax contributions made by an employee to a cafeteria plan (i.e., salary reduction contributions). In general, except for certain purposes, salary reduction contributions are treated as employer contributions. Special rules apply to the treatment of salary reduction contributions for pur-

poses of the 90-percent/50-percent test and for the 50-percent test. These rules are designed to permit an employer to treat salary reduction contributions as employer contributions if doing so does not permit the avoidance of the tests.

Notwithstanding these general rules, the Secretary of the Treasury is authorized to establish rules under which salary reduction shall or shall not be taken into account as an employer-provided benefit to prevent avoidance of the nondiscrimination rules. These rules are to take into account the fact that salary reduction contributions provide a tax-benefit to high-paid employees, but represent employee cost for low-paid employees. Consequently, these rules may also permit salary reduction to be characterized differently with respect to highly compensated and rank and file employees.

Separate lines of business; excludable employees

In general, all of the employees of the employer, as well as the employees of certain related employers (e.g., subsidiary or affiliate corporations) are required to be taken into account in applying the nondiscrimination tests of section 89. There are, however, several exceptions to this rule.

Separate lines of business or operating units.—If the employer has separate lines of business or maintains separate operating units, each separate line of business or operating unit may be tested separately by taking into account only those employees in that line of business or operating unit. In general, if a business location of the employer is located more than 35 miles from another location and meets certain other requirements, that location may qualify as a separate operating unit for section 89 purposes.

Under present law, headquarters employees of an employer generally may not be treated as employed in a separate line of business or operating unit. Special rules apply to determine how such employees are to be allocated to other lines of business or operating units of the employer.

Under present law, a line of business or operating unit will not be treated as separate unless, among other things, the line of business or operating unit satisfies guidelines prescribed by the Secretary or the employer obtains a determination from the Secretary that the line of business or operating unit may be treated as separate. A separate line of business or operating unit is treated as meeting this requirement if it satisfies a safe harbor rule (sec. 414(r)(3)). The Secretary's guidelines are to provide additional circumstances under which lines of business or operating units may be treated as separate.

Excludable employees.—Certain employees are disregarded in testing for discrimination under section 89. Generally, employees in the following categories are disregarded: (1) employees who normally work less than six months per year; (2) employees who normally work less than 17.5 hours per week; (3) certain nonresident aliens; (4) employees who are under 21 years of age; and (5) employees who have less than one year of service with the employer (or six months with respect to a health plan providing core health coverage).

Part-time employees

Generally, if a part-time employee normally works at least 17.5 hours a week, then the employee is required to be taken into account when an employer tests its plans for discrimination under section 89. Section 89 contains a number of exceptions to the requirement that employees who normally work 17.5 hours or more are required to be taken into account. First, the employer may disregard any employee if the employee has coverage under another employer's health plan (e.g., a spouse's plan). In addition, section 89 contains rules that permit an employer to proportionately reduce the coverage it makes available or provides to its part-time employees in relation to the hours worked.

Finally, a special rule relating to part-time employees is available to small employers (those with fewer than 10 employees). For plan years beginning in 1989, such employers may disregard those employees who work less than 35 hours a week, and for plan years beginning in 1990, the employer may disregard those employees who work less than 25 hours a week. For subsequent plan years, the 17.5-hour rule applies.

Employees covered by a collective bargaining agreement

In general, if any employee covered under a collective bargaining agreement has health coverage, that employee and other employees in the same bargaining unit are taken into account for purposes of determining whether an employer meets the section 89 nondiscrimination rules. The effect of this rule is that, in most cases, the employer cannot disregard employees covered by collective bargaining agreements.

Family coverage

In enacting section 89, the Congress was concerned that an employer might fail the numerical nondiscrimination tests with respect to health plans covering families simply because those employees with families are disproportionately highly compensated. Therefore, several special rules apply under section 89 with respect to family coverage.

For purposes of the eligibility tests, if the employee has the opportunity to enroll in a plan providing family coverage, such coverage is treated as available to the employee without regard to whether or not the employee actually has a family.

In applying the 75-percent benefits test and the 80-percent coverage test, the employer may test its single coverage and family coverage separately. Thus, if the employee confirms to the employer that he or she does not have a family (e.g., a spouse or dependents), the employer need not consider that employee in testing its family health plans. In addition, if an employee is offered coverage (such as family coverage) at no cost to the employee and the employee declines to participate, that employee may be disregarded for purposes of testing.

Coverage from another employer

The Congress concluded in 1986 that an employer should not fail to satisfy the section 89 requirements merely because an employee

declines coverage if the employee has health coverage through another employer (for example, through a spouse's employer). Therefore, employees who confirm to an employer that they have other health coverage may be disregarded in applying the nondiscrimination tests of section 89. If the employer treats employees with families separately as discussed above, then the employer may disregard an employee whose family has other coverage.

Valuation of health coverage

In order for an employer to compare differing health coverages under section 89, the employer must assign a value to each coverage. The Secretary of the Treasury is to establish tables prescribing the relative values of different types of health coverage. These tables are to be effective as of the later of (1) the first testing year beginning after the issuance of the tables, or (2) the date specified by the Secretary.

Until the issuance of valuation rules by the Secretary, an employer may use any reasonable method to value its health coverage. For example, the employer may use the cost of the coverage determined in the same way health coverage cost is determined under the health care continuation rules (sec. 4980B).[1]

There is a special permanent valuation rule for collectively bargained plans maintained by more than one employer (called multiemployer plans). For purposes of section 89, the value of coverage provided by the employer is generally equal to the amount the employer contributes under the collective bargaining agreement on behalf of its employees. Thus, for example, if the contract requires that an employer contribute 55 cents for health coverage for each hour worked by an employee, then the value of the coverage provided to that employee is 55 cents times the number of hours worked.

Testing procedures

Under section 89, an employer chooses a testing year on which to base its testing. Within this year the employer selects a day (called the testing date) on which to determine who are its employees and what coverage is available and provided to such employees. In general, testing is based on the facts in existence on that one date. However, the testing day data is required to be adjusted to reflect changes in plan design and changes in elections by highly compensated employees that have occurred during the year. These adjustments are necessary in order to have the limited data available on the testing day reflect what actually occurred during the year.

Highly compensated employees

A highly compensated employee is an employee who, during the year or the preceding year (1) was a 5-percent owner of the employer, (2) received compensation in excess of $81,720, (3) was an officer of the employer and received compensation in excess of $45,000, or

---

[1] In general, the health care continuation rules require that employers provide their employees (and certain other individuals) the opportunity to participate for a specified period in the employer's health plan despite the occurrence of a qualifying event that otherwise would have terminated such participation. Employers are permitted to charge the individual a specified amount for the coverage, based on the employer's cost of providing the coverage.

(4) received compensation in excess of $54,480 and was in the top-paid 20 percent of employees. The dollar limits are indexed for inflation. In lieu of calculating the top-paid 20 percent of employees, the employer may elect to treat all employees with compensation in excess of $54,480 as highly compensated employees. An employer is treated as having at least one officer even if that officer has less than $45,000 of compensation.

Former employees

Former employees are taken into account in determining whether an employer meets the requirements of section 89. However, the employer tests former employees separately from active employees. Thus, former employees are not considered when the employer tests its plans relating to active employees. Further, an employer is generally permitted to disregard employees who separated from service prior to January 1, 1989.

Sanctions

If an employer's plan fails to satisfy the section 89 nondiscrimination rules, then the highly compensated employees participating in the plan must include in income the value of the portion of the coverage that is discriminatory (the "discriminatory excess"). The discriminatory excess is determined based on the coverage received that is in excess of the coverage that could be provided if the plan were nondiscriminatory. The amount includible in income is based on the discriminatory excess coverage, that is, the premium paid for the coverage, not on the amount of reimbursements received under the plan. Thus, if the nondiscrimination rules are violated, a highly compensated employee is not required to include a greater amount in income merely because he or she was sick during the year.

The employer is subject to an excise tax if the employer fails to report properly on an employee's W 2 the amount includible in the employee's income due to failure to satisfy the section 89 rules. The excise tax does not apply if the failure to report the proper amount was due to reasonable cause.

Qualification rules

In general

The qualification rules of section 89(k) are designed to ensure that a plan meets certain basic minimum requirements. In general, these rules require that a plan be: (1) in writing; (2) maintained for the exclusive benefit of employees; (3) legally enforceable; and (4) established with the intention that it be maintained for an indefinite period of time (the permanence requirement). In addition, an employer must give its employees reasonable notice of the benefits provided under the plan.

Plans subject to the qualification requirements

The qualification rules apply to the following types of benefit plans: (1) health plans; (2) group-term life insurance plans; (3) cafeteria plans; (4) voluntary employees' beneficiary associations (VEBAs); (5) dependent care assistance programs; (6) qualified tui-

tion reduction programs; and (7) fringe benefit programs providing no-additional-cost services, employer-provided eating facilities, and qualified employee discounts.

Sanction

If a plan fails to satisfy the qualification requirements, then the employer pays benefits under an ad hoc reimbursement program that attempts to convert fully taxable compensation into nontaxable benefits. Consequently, if such requirements are not met, then all employees participating in the plan are required to include in income the value of benefits (e.g., reimbursements) received under the plan. This sanction may be imposed on all employees whether or not they are highly compensated employees.

The penalty imposed upon an employer for failure to report properly the amount includible in income on an employee's W-2 applies to failures to report income includible as a result of failure to satisfy the qualification rules of section 89.

Effective date of section 89 rules

In general, the nondiscrimination rules and the qualification requirements of section 89 are effective for plan years beginning on or after January 1, 1989. A delayed effective date applies to plans maintained pursuant to one or more collective bargaining agreements. The effect of this delayed effective date is that in applying the nondiscrimination tests, participants in such collectively bargained plans may be disregarded until the delayed effective date at the employer's election. Treasury regulations contain transition rules that have the effect of delaying the effective date of certain of the section 89 rules to July 1, 1989. In addition, the Treasury Department announced, on May 1, 1989, that the delay to July 1, 1989, in the regulations would be extended to October 1, 1989.

Reasons for Change

The tax-favored treatment of employer-provided health coverage reduces the Federal income tax base and reduces Federal budget receipts. In enacting the present-law section 89 nondiscrimination rules as part of the Tax Reform Act of 1986, Congress was concerned that these costs were justifiable only if the tax benefits further important social policy objectives. Nondiscrimination rules of the type contained in section 89 were felt to be a necessary part of this public policy rationale because they permit the exclusion of employee benefits only if the benefits are provided to a broad group of employees on a nondiscriminatory basis.

However, the present-law nondiscrimination rules present significant administrative costs and recordkeeping burdens for employers. For example, under present law, in some cases an employer is required to obtain and maintain sworn statements from its employees attesting to the employee's family status. In addition, the employer must determine what individuals have elected to participate in each plan of the employer. Many employers do not currently maintain such information in the systematic manner that is required to demonstrate compliance with section 89.

Present law contains several different methods of demonstrating compliance with the nondiscrimination rules. While these rules add additional flexibility for employers, they also serve to make the rules complex.

In light of the administrative burdens the present-law rules place on employers, the committee believes it is appropriate to repeal the existing rules and to replace them with simplified rules.

In order to provide employers the opportunity to conform to the changes in the rules, a one-year delay of all rules is provided.

Explanation of Provisions

One-year delay of all section 89 rules

Under the bill, new nondiscrimination rules and modified qualification rules are delayed for one year and are effective for plan years beginning after December 31, 1989. Prior to that date, the nondiscrimination rules under section 105(h) as it existed immediately prior to the passage of the Tax Reform Act of 1986 apply to certain self-insured health plans.

Repeal present-law section 89 nondiscrimination rules and replace with simplified test

The bill repeals the current section 89 nondiscrimination rules for health plans and replaces them with a single test (the "eligibility" test). In general, an employer's health plan passes the new test if the plan contains no discriminatory provision and at least one affordable plan (or a group of plans) providing primarily core health coverage is available to at least 90 percent of the employer's employees. A plan is deemed affordable if the cost to employees does not exceed 40 percent of the total cost of the plan in the case of individual coverage, or 40 percent of the total cost of the plan in the case of family coverage (including coverage for the employee).

Under the bill, the eligibility test is satisfied if the plan does not contain any discriminatory provision and core (or primarily core) health coverage is available to 90 percent of the employees of the employer. This 90-percent test may be met by looking at all affordable health plans maintained by the employer. A plan that can be taken into account in applying the 90-percent test is called a qualified core health plan. This test does not require that the employer only offer health plans meeting the employee contribution requirements. Rather, the employer can offer a full array of plans as long as the availability test is met by at least one (or a group of) plans. If the employer fails to meet this new eligibility test, then the value of all health coverage provided to highly compensated employees is includible in the taxable income of the highly compensated employees.

The eligibility test under the bill does not require that a particular level of coverage be provided to employees. Instead, in order for all or a portion of the coverage provided to highly compensated employees to be provided on a tax-favored basis, some health coverage must be available to a broad segment of employees. By using a requirement that limits the percentage of the total cost that may be required of an employee, the bill ensures that the employer subsidizes a portion of core health coverage, while also providing the

employer flexibility in those instances where the cost of coverage varies because of geographic locale.

As under present law, the bill generally defines core health coverage as coverage for comprehensive major medical and comprehensive hospitalization benefits. At the election of the employer, core health coverage may also include any benefits permitted to be taken into account by the Secretary. Core health coverage generally does not include coverage under dental, vision, disability, and accidental death and dismemberment plans. Flexible spending arrangements are not core health plans nor can such plans be a part of a qualified core health plan. This rule does not prevent an employer from maintaining a flexible spending arrangement, it simply affects how such arrangements are treated for purposes of the nondiscrimination rules. Flexible spending arrangements are defined as under section 125 of the Code (including applicable regulations).

In determining what plans may be considered available for purposes of the eligibility test, the bill limits the percentage of the total cost of a plan that the employer may require an employee to pay. For individual coverage, the mandatory employee contribution cannot exceed 40 percent of the total cost of the plan for the individual generally determined under the health care continuation rules. For family coverage, the mandatory employee contribution cannot exceed 40 percent of the total cost determined in the same manner. Under the bill, this 40 percent limitation applies to family coverage that includes coverage for the employee. Thus, to the extent that a plan providing individual coverage requires a lower employer premium than the maximum level of employee premium under the bill, the additional employer subsidy under such plan may be used to help the employer meet the maximum employee premium requirements for a family plan. However, if the employer does not provide individual coverage meeting the employee contribution requirements under the bill, the employer does not meet the eligibility test. This is the case without regard to whether the employer maintains a family plan that meets the maximum employee premium requirements.

As under present law, the bill provides that the employer-provided coverage under a plan may be excluded from the taxable income of a highly compensated employee only if the plan does not contain any provision that (by its terms, operation, or otherwise) discriminates in favor of highly compensated employees. The purpose of the nondiscriminatory provision requirement is to preclude executive-only plans and other inherently discriminatory practices. As under present law, the requirement applies to the method and circumstances under which an employer determines whether it meets the requirements of section 89. For example, the requirement applies to the designation of a testing date.

The following examples illustrate the eligibility test.

Example 1.—An employer makes available to all employees a health plan providing core health coverage. No other health plans are available to the employees. The plan provides employee-only coverage which has a total premium cost of $1,000 and requires a $250 employee contribution and provides family coverage (for the employee and the employee's spouse or dependents) which has a

total cost of $2,500 and requires a $500 employee contribution. The plan passes the eligibility test and no further testing will be required by the employer.

Example 2.—An employer maintains several health plans for its employees. Among these plans is a plan that provides core health coverage that is available to all employees. The plan has a total premium cost of $1,000 for employee-only coverage and requires an employee contribution of $250. This plan is a qualified core health plan and the employer meets the eligibility test without regard to the characteristics or employee contribution requirements of the other plans maintained by the employer.

Example 3.—An employer maintains two plans providing core health coverage. One plan is an indemnity plan and is available to employees at a cost of $200 per year for employee-only coverage (total annual premium cost of $1,200) or at a cost of $700 per year for family coverage (total annual premium cost of $2,000). This plan is available to 40 percent of the employees of the employer. The other plan is an HMO requiring no employee contribution and is available to 70 percent of the employer's employees. When considered together, 90 percent of the employer's employees are eligible for one or both of the plans. Both plans are qualified core health plans and may be considered for the eligibility test because the cost to employees under both plans is within the mandatory contribution range and both plans primarily provide core health coverage. Because 90 percent of the employees can participate in one of the two plans, then the employer meets the eligibility test.

Benefits test

In order to provide employers flexibility in offering multiple health benefits with differing levels and percentages of employer contributions, a separate benefits test is provided. This test does not apply in cases where the employer only makes one health plan available, or where all the employer's plans meet the maximum employee contribution requirements and are available to 90 percent of all employees. The purpose of the benefits test contained in the bill is to ensure that highly compensated employees do not receive a disproportionately higher value of employer-provided coverage than the level of employer-provided coverage that is available to a broad group of employees. Under the bill, the maximum tax-favored benefit that a highly compensated employee may receive is generally 133 percent of the employer-provided coverage for the employee-only coverage that may be taken into account in applying the eligibility test. However, if a highly compensated employee elects a specific level of family coverage, and if the employer maintains a plan that provides family coverage that meets the requirements under the bill for the eligibility test, then the tax-favored employer-provided coverage is increased to 133 percent of the employer-provided family coverage taken into account in applying the eligibility test. If the employer maintains more than one core health plan providing family coverage (e.g., employee plus one or employee plus two), then for purposes of determining the limitation on benefits, an employee electing a specific level of family core coverage may receive tax-favored coverage based upon the employer subsidy under that plan. If the plan that is elected is not a quali-

fied core health plan or a part of such a plan that meets the eligibility test, then any qualified core health plan with a smaller employer-provided value that passes the eligibility test may be used to determine the limitation on benefits under the benefits test.

A highly compensated employee is not treated as electing a family plan unless the employee has elected a core health plan providing family coverage (without regard to whether the plan elected meets the eligibility test). Thus, for example, an employee that elects only a flexible spending arrangement has not elected family coverage.

For purposes of the benefits test, an employer may aggregate certain plans in determining the employer-provided benefit available to 90 percent of the employees. Because these rules are permissive, an employer is not required to aggregate plans and may designate any smaller level of employer-provided benefit to be multiplied by 133 percent, as long as that benefit satisfies the 90-percent eligibility test. However, an employer is likely to use the highest level of employer-provided benefit that satisfies the eligibility test in calculating the benefit to be multiplied by 133 percent.

Under the aggregation rule, the employer may increase the level of benefit available to employees by aggregating two or more plans if such plans are available to the same group of employees and, when combined, such aggregated plans constitute a qualified core health plan (i.e., are primarily composed of an employer-provided benefit relating to core health coverage and continue to meet the maximum employee contribution limitation on an aggregate basis). As noted above, flexible spending arrangements cannot be part of a qualified core health plan for testing purposes.

For example, if a dental plan with an employer-provided benefit of $499 and a core health plan with an employer-provided benefit of $501 are available to the same employees and the two plans meet the maximum contribution limitation when considered together, then such plans may be treated as one qualified core health plan with an annual employer-provided benefit of $1,000. If 90 percent of the employees are eligible for this plan or for other qualified core health plans with at least the same employer-provided benefit, the benefits test would be met if no highly compensated employee received an employer-provided benefit in excess of $1,330 (133 percent of $1,000). Of course, for purposes of the aggregation rules, overlapping coverage under the plans may not be considered more than once in determining the employer-provided benefit under the combined plans.

For purposes of testing under the benefits test, the bill makes permanent the temporary valuation rule under present law. Thus, as under present law, the employer may use any actuarially reasonable valuation method. In addition, the employer may use the cost of the coverage as that cost is determined under the health care continuation rules. The employer may also make reasonable adjustments to cost, for example, adjustments for differences in cost in different geographic areas. As under present law, all of an employer's health plans are to be valued under the same actuarially reasonable valuation method.

Any employer-paid premium received by a highly compensated employee in excess of the level of employer-paid premium that

meets the benefits requirement is includible in the taxable income of such employee. As under present law, in determining the amount that is actually in excess of the benefits limitation and thus includible in the taxable income of the high paid, only cost as determined under the health care continuation rules may be used, with an adjustment for utilization.

As under present law, if an employer tests based on a valuation method other than actual cost, the amount of includible income is determined as follows. First, the employer determines the percentage of coverage that exceeds the amount permissible under the benefits test. This percentage is then multiplied by the employer's actual cost in providing the entire coverage to determine the includible amount of the coverage. Such actual cost is to be determined in the same manner as the applicable premium for purposes of the health care continuation rules, except that, as stated above, uniform adjustments are permitted for utilization.

For example, assume the benefits limitation for a highly compensated employee is $1,330. If the employee receives $1,500 in coverage based on the same valuation method, then the percentage of includible coverage is 11.3 percent ($170/$1,500). This percentage is then applied to the actual cost of the coverage received by the highly compensated employee to obtain the taxable benefits with respect to such employee.

The benefits test is illustrated by the following examples.

Example 1.—An employer maintains only two health plans: an indemnity plan and an HMO. Both plans are available at no cost to over 90 percent of the employees. An employee may choose either plan. Under this example, there is no need to utilize the benefits test because the highly compensated employees can only receive an employer-paid premium equal in value to the employer-paid premium available to 90 percent of all employees.

Example 2.—An employer maintains two health plans: an indemnity plan providing core health coverage that is available to all employees, and a dental plan available only to 20 percent of employees (including both highly and nonhighly compensated employees). Neither plan requires employee contributions. The employer cost for the indemnity plan is $1,400 as determined under the health care continuation coverage rules. The cost for the dental plan is $500. Under the bill, if a highly compensated employee participates under both plans, then the taxable portion of the premium to such employee is $38 ($1,900 less (1.33 x $1,400)).

Example 3.—An employer maintains several health plans. Three plans are core health plans. Each core plan is available to over 90 percent of all employees. The employer cost of each of the three core plans is $500, $1,000 and $1,500 respectively. The maximum excludable benefit that may be received by any highly compensated employee is $1,995 ($1,500 x 1.33). Thus, any highly compensated employee would have taxable income to the extent that the employee receives over $1,995 in health coverage.

Example 4.—An employer maintains several health plans. Among these plans is a family core indemnity plan with a total premium cost of $2,500, and a required after-tax employee contribution of $1,100. The employer also maintains a family dental plan with a total premium cost of $600 and a required after-tax employ-

ee contribution of $100. Assuming these plans are available to all employees and that the employer maintains an employee-only core health plan that meets the requirements of the eligibility test, a highly compensated employee electing family coverage under the described core health plan may exclude $2,527 in health benefits (1.33 x $1,900) because, when combined, these plans constitute a qualified core health plan. The employee contribution limitation is met because the total employee cost for the plans ($1,200) is less than 40 percent of the total cost for both plans ($3,100).

Example 5.—An employer maintains two core health plans. One plan is an employee-only plan with a total premium cost of $1,250 and a required after-tax employee contribution of $250 per year. The other core plan provides coverage for the employee's spouse and dependents with a total premium cost of $1,500 and a required employee contribution of $1,200. Thus, the family plan does not meet the 40-percent employee contribution limitation. Assuming that the employee-only plan is available to 90 percent of the employees of the employer, a highly compensated employee may exclude $1,330 in coverage ($1,000 x 1.33) whether that employee enrolls in the individual plan or in both the individual plan and the family plan.

Special rules for small employers

The bill provides significant relief for small employers. First, the bill has created a design-based test. An employer can know at the time it offers its plans to its employees that it meets section 89.

Second, the bill modifies several rules in the excludable employee area. Among these changes is a rule permitting an employer with 20 or fewer employees to disregard employees for purposes of the eligibility test who are determined to be uninsurable by reason of a medical condition by the insurance company that provides core health coverage to the employees of the employer. The insurance company's determination is to be based on its customary standards for insurability applied to groups of that size.

The bill contains a rule designed to benefit small employers in determining the number of employees to whom coverage must be made available. Under the bill, in determining the number of employees who must be eligible for coverage under the eligibility test, an employer may round down to the nearest number of employees. For example, if an employer has 11 employees, only 9 must have coverage available if the employer is to meet the eligibility test.

The bill clarifies that for testing under section 89, a small employer may use average premium cost even if the employer's premium is calculated on an individually rated basis.

Finally, for employers with 20 or fewer employees, the written plan requirement under the qualification rules may be satisfied by the written insurance contract that is currently in effect relating to the coverage provided by the employer.

An employer is a small employer under the bill if it normally employs 20 or fewer employees per day. Of course, the aggregation rules applicable for the determination of who is an employer for purposes of section 89 apply in determining whether an employer qualifies as a small employer under the bill.

Part-time employees

Under the bill, employees who normally work less than 30 hours a week are disregarded for purposes of the nondiscrimination tests (compared with 17.5 hours under present law).

Leased employees

Under the bill, the present-law historically performed test is repealed and replaced with a new rule defining who must be considered a leased employee. This change is made because the proposed regulations under the leased employee rules (sec. 414(n)) are overly broad in defining who may be a leased employee. Under the bill, the proposed regulations are no longer valid.

Under the bill, an individual will not be considered a leased employee unless the individual is under the control of the recipient organization. The determination of whether an individual is controlled by the employer is based on all facts and circumstances. Among the factors that are relevant in this determination are whether the recipient organization: (1) prescribes the individual's work methods; (2) supervises the individual; (3) sets the individual's working hours; and (4) sets the individual's level of compensation. Other factors that may be considered include those that are relevant for determining whether the employer is responsible for employment taxes on the compensation paid to the individual. The Secretary may designate other relevant factors. It is not necessary that all these factors indicate that the individual is under the control of the employer in order to find that such individual is a leased employee. Nor is it necessary that the recipient organization be responsible for employment taxes in order to find that the individual is a leased employee because, if the recipient organization is liable for employment taxes, the individual is an employee of the organization who generally must be taken into account. The bill does not alter the definition of a common-law employee, nor the rules that such employees are to be taken into account unless specifically excluded (e.g., under the rule permitting part-time employees to be excluded).

The bill clarifies present law in that support staff of professionals continue to be treated as leased employees (to the extent they are not already considered employees because they are common-law employees). In general, professionals include those individuals defined as such under Treasury regulations relating to the minimum participation requirements (sec. 401(a)(26)) and the minimum coverage requirements (sec. 410). This clarification with respect to the support staff of professionals is not intended to create an inference with respect to the support staff of nonprofessionals.

Under the bill, persons who perform services incidental to the sale of goods or equipment or incidental to the construction of a facility are generally not leased employees. This rule does not extend to the operation (including supervision over such operation) of the goods, equipment, or completed facility.

Under the bill, the revised definition of leased employee is for taxable years beginning after December 31, 1983.

Union employees

The bill provides that plans maintained pursuant to collective bargaining agreements are tested separately with respect to employees covered by the agreement. The separate testing rule applies on a bargaining unit by bargaining unit basis. In addition, multiemployer plans are generally exempted from the nondiscrimination rules of section 89. Finally, employees that are covered under the Davis-Bacon Act are excluded employees for purposes of the nondiscrimination rules.

With respect to the rule allowing a de minimis number of professionals in a collectively bargained or multiemployer plan, it is intended that in defining who is a professional and in determining what constitutes a de minimis number of such employees, the Secretary will prescribe rules similar to those applicable to the minimum participation requirements (sec. 401(a)(26)) and minimum coverage standards (sec. 410) under present law.

Former employees

As under present law, the nondiscrimination tests are applied separately to former employees of the employer. Employees who separate from service prior to 1990 are not considered for purposes of testing. In addition, the bill provides that in determining whether former employees meet the nondiscrimination requirements, the employer may consider only those employees that meet certain reasonable eligibility requirements relating to age and/or service. The Secretary is authorized to impose restrictions on instances where age or service requirements are not reasonable and may allow other eligibility criteria to be imposed by the employer.

In applying the nondiscrimination tests to former employees, the mandatory employee contribution limits do not apply. Thus, as long as 90 percent of the employees in a class of former employees being tested are eligible for a core health plan on the same terms, that plan may be a qualified core health plan without regard to whether it meets the limitation on employee contributions.

Excluded employees; individuals participating in certain government-sponsored programs

Under the bill, certain individuals are excluded for purposes of determining whether the employer meets the nondiscrimination tests. In addition to part-time employees, other individuals are excluded from testing. Excluded employees include employees with less than 6 months of service, seasonal employees, non-resident aliens, and students.

Under the bill, an employee with less than 6 months of service with the employer may be excluded when the employer determines whether it meets section 89. A special rule applies if the employer requires different waiting periods with respect to health coverage. If the employer maintains different waiting periods, then those employees eligible under each waiting period are to be tested separately to determine whether the plan or plans providing such coverage meet the requirements of the bill. In the event that the plan does not meet such requirements, then the taxable benefit of any highly compensated employee includes the value of the coverage

for that period of time that the employee participated in the plan prior to the time the employee would have been eligible under a plan that met the requirements of the bill. Of course, the taxable benefit of the employee may be greater than such amount if the plan fails to satisfy some other provision of the bill (e.g., the plan fails the nondiscriminatory provision requirement).

The bill adds new categories of individuals who may be excluded from consideration under section 89. These individuals include (1) senior citizens employed pursuant to Title V of the Older Americans Act or under the Environmental Programs Assistance Act of 1984; (2) students under certain programs qualified under Title VIII of the Higher Education Act of 1965; (3) certain disabled individuals; and (4) inmates in state, local, or Federal correctional facilities. The Secretary is authorized to designate certain additional classes of individuals as excluded employees if treatment of such individuals as employees is inappropriate in light of the policy purpose underlying the Federal or state program authorizing or encouraging such participation and the nondiscrimination rules. This rule excluding certain individuals is not intended to create any inference with regard to the appropriate treatment of such individuals as employees under other provisions of the Code.

Under present law, if the employer provides coverage to an otherwise excluded employee, the employer may test all excluded employees of that class separately from other employees. The bill modifies this rule and allows the employer to disregard excluded employees that receive coverage. A similar rule applies to all classes of excluded employees, except those employees that are excluded because they have not yet met the 6 month service requirement. Present law (including regulations) continues to apply to these employees.

Definition of highly compensated employee

The bill amends the definition of who constitutes a highly compensated employee for purposes of section 89. Under present law, officers with compensation over $45,000 (indexed) are highly compensated employees. However, an employer will always have at least one highly compensated officer regardless of that officer's compensation. Under the bill, only officers with compensation in excess of the $50,000 limitation (indexed to $54,480 for 1989) that is otherwise applicable for determining who are highly compensated employees must be considered highly compensated employees. This rule will benefit employers who, but for the present-law rule, would have no highly compensated employees. These employers include many municipalities and tax-exempt organizations.

In addition, the bill requires that, beginning in 1990, the compensation levels specified in the definition of highly compensated employee will be rounded to the nearest $1,000.

Cafeteria plans

The bill provides special rules for the treatment of salary reduction contributions. These rules do not apply to dependent care assistance programs, including flexible spending arrangements providing only dependent care assistance expenses. For purposes of the eligibility test, the general rule is that salary reduction contribu-

tions are employee contributions. Thus, a plan does not meet the eligibility test to the extent that such contributions (and other employee contributions) exceed the 40-percent limitation on employee contributions.

For purposes of both the eligibility and benefits tests, certain salary reduction contributions are treated as an employer-provided benefit. These salary reduction amounts are those that are available to the employee only to the extent that: (1) the employee indicates to the employer that he or she has core health coverage elsewhere, either through another employer or the employer of a spouse or dependent; (2) the employee does not elect any core health plan maintained by the employer; and (3) such amount is available in cash to the employee. These salary reduction amounts are considered employer-provided in determining whether the plan meets the eligibility test. They are also treated as employer-provided in determining the employer-provided portion of the qualified core health plan that is multiplied by 1.33 to determine the benefits limitation under the benefits test (but only to the extent that such amounts relate to the plan in question).

In determining the employer-provided portion of the qualified core health plan that is multiplied by 1.33 to determine the benefits limitation under the benefits test, certain salary reduction amounts other than those amounts described in the preceding paragraph may also be considered (to the extent that such amounts relate to the plan in question). These additional salary reduction contributions are treated as employer-provided to the extent they do not exceed the employer-provided premium relating to such plan, excluding all salary reduction contributions.

For purposes of determining the employer-provided coverage provided to the highly compensated employees, all salary reduction contributions are considered employer-provided.

The treatment of salary reduction contributions under the bill is illustrated by the following examples:

Example 1.—A plan has a total cost of $1,500 and a required employee contribution of $400, paid through a salary reduction agreement. Under the plan, if an employee has other core health coverage and elects no core health coverage, the employer will pay the employee $300. Thus, there are $700 of salary reduction contributions under the plan. Assuming that this plan is available to 90 percent of the employees, the plan will meet the eligibility test. This is because the required employee contributions ($400) are less than 40 percent of the total cost of the plan ($1,500). The employer-provided portion of the plan for purposes of multiplying by 1.33 under the benefits test is $1,500. This amount is composed of the $800 of employer-provided contributions (excluding salary reduction), $300 of salary reduction that is given preferential treatment under the special rule described above, and the remaining salary reduction under the plan ($400). The $400 is treated as employer-provided because it does not exceed the $800 in nonsalary reduction under the plan. Thus, the benefits limitation for the highly compensated employees is $1,995 ($1,500 x 1.33).

Example 2.—An employer maintains three core health plans, Plans A, B, and C, that provide employee-only coverage. All employees must elect coverage under one of the plans. Plan A has no

required employee contribution and has a total cost of $1,000. If an employee elects coverage under Plan A, then the employer will pay the employee $1,000 in cash. Plan B has a total cost of $1,600. If the employee elects Plan B, then the employee receives $400 in cash. Plan C has a total cost of $2,000. If the employee elects Plan C, the employee receives no cash back.

Under the bill, the amounts available in cash are treated as salary reduction contribution and not as qualified cash payments. This is because employees have coverage under a core health plan of the employer. Thus, Plan B requires $600 in salary reduction contributions and Plan C requires $1,000 in salary reduction contributions. Such contributions are treated as employee contributions under the eligibility test. Thus, Plan A and Plan B meet the 40-percent limitation on employee contributions. Using the plan with the largest value that meets the 40-percent requirement (i.e., Plan B) and assuming Plan B is available to 90 percent of employees, the base to be multiplied by 1.33 in this example has an employer-provided value of $1,600. The entire salary reduction amount related to Plan B may be included in the base because it is matched with other employer-provided dollars that are not salary reduction. Thus, the benefits limitation in this case is $2,128 ($1,600 x 1.33). If the employer maintains no other health plans, then no highly compensated employee will have a taxable benefit under this example by reason of exceeding the benefits limitation.

Group-term life insurance

Under present law, group-term life insurance plans are subject to the section 89 nondiscrimination rules. To further simplify section 89, the bill provides that the nondiscrimination rules in effect prior to the Tax Reform Act of 1986 (with certain modifications) apply to group-term life insurance for years beginning in 1989 (sec. 79(d)).

For years beginning after December 31, 1989, the bill makes certain conforming changes to the pre-Tax Reform Act rules to take into account changes in the law. First, the rules are modified in order to compare highly and nonhighly compensated employees rather than key employees and all other employees. Second, section 79 will include the Tax Reform Act rule that group-term life insurance is discriminatory to the extent it takes into account compensation in excess of $200,000 in determining a multiple of compensation benefit under a plan.

Under the bill, accidental death and dismemberment plans (AD&D) are treated as group-term life insurance plans solely for purposes of nondiscrimination testing. Thus, a death benefit under an AD&D plan that is based on a uniform multiple of compensation (not in excess of the $200,000 limitation) is not discriminatory solely because of the use of such multiple. In addition, traditional business travel insurance with a multiple of compensation benefit, while treated as a health plan, is not considered discriminatory if its value is de minimis.

Dependent care assistance programs

Under the bill, section 89 does not apply to dependent care assistance programs. For plan years beginning in 1989, the nondiscrimination rules under section 129(d) are applicable to such plans and

are modified in the following respects. First, if a plan fails to meet the requirements of section 129(d), only highly compensated employees must include benefits under the program in gross income. Second, if a dependent care assistance program fails the 55-percent benefits test contained in section 129(d)(7), then the highly compensated employee must include in gross income only that amount of benefit in excess of that level of benefit that would meet the benefits test. Finally, under the bill, the 55 percent benefits test can be applied on a line of business basis (sec. 414(r)).

Election not to test

Under the bill, an employer may elect to forego testing and instead include the employer premium for health coverage as taxable income on the W-2 of highly compensated employees.

Qualification rules

In general

An employer's fringe benefit plans are required to meet certain minimum standards. These standards require that a plan be in writing, employees be notified of plan provisions, the plan be maintained for the exclusive benefit of employees, the plan be legally enforceable, and that the plan is intended to be maintained for an indefinite period of time (the permanence requirement). Under present law, if an employer's plan does not satisfy the qualification requirements, then all employees must include in income the value of benefits (e.g., reimbursements for health care) received under the plan.

The bill replaces the present-law sanction for failure to satisfy the qualification rules with an excise tax on the employer and makes certain modifications to the qualification standards. Under the bill, the qualification rules no longer apply to any plan the benefits under which are excludable under section 132. Thus, the qualification requirements do not apply to no-additional-cost services, qualified employee discounts, or employer-provided eating facilities. As under present law, an employer's failure to meet the qualification requirements does not, in and of itself, create a private right of action on behalf of employees, nor does it create any inference with respect to rights of action under other statutes or laws.

As part of the modifications to the sanction for failure to satisfy the qualification rules, the bill removes the rules from section 89 and adds the rules to new Code section 4980C. As is the case generally under the bill, it is intended that legislative history and guidance by the Secretary relating to the qualification rules under present law continue to apply to the rules as modified by the bill, except to the extent inconsistent with the provisions of the bill. This reference to the current proposed regulations under section 89(k) is not intended to preclude the Secretary from modifying current guidance or providing further guidance to employers with respect to how to comply with the qualification rules.

For example, as under present law, a plan generally meets the permanence requirement if the plan provides coverage for a continuous 12-month period. If the plan is in effect for less than 12 months, the employer generally will not violate the permanence re-

quirement upon a showing of a substantial independent business reason for the modification or termination of the plan. Similarly, the notice requirement is met if a third party, such as an insurance company, provides notice to the employees of the plan.

The bill modifies the exclusive benefit requirement. This requirement is not violated merely because nonemployees or other individuals without a service nexus to the employer are covered under the plan on an after-tax basis. As under present law, the exclusive benefit rule is not intended to override other provisions with respect to who may be covered under a plan (e.g., rules relating to section 125 and section 501(c)(9)).

It is intended that the notice requirement is satisfied by a notice that contains the material that would be required to be contained in the Summary Plan Description required under the Employee Retirement Income Security Act of 1974 (ERISA) relating to the current plan, if the notice if provided by the time required under the Code. It is not intended that this is the only way the notice requirement may be satisfied.

Sanction for failure to comply

The present-law sanction for failure to satisfy the qualification rules may penalize employees who have no control over the failure to satisfy the rules. Thus, the bill replaces the present-law sanction with an excise tax on the employer.

Under the bill, no penalty applies with respect to a failure to satisfy the qualification rules if the employer corrects the failure to comply within 6 months of the date the employer knew or should have known of such failure. If the employer does not correct the failure within this 6-month period, then an excise tax is imposed. The excise tax is equal to 34 percent of the costs paid or incurred by the employer for coverage under the plan that relates to the failure. In the event of a willful failure to comply with the qualification requirements, the tax is imposed from the date of the failure without regard to any subsequent correction. Under the bill, the Secretary is authorized to waive the excise tax in whole or in part if the failure is not due to willful neglect and to the extent the payment of the tax would be excessive relative to the failure involved.

For example, an employer will not be charged with knowledge of a failure to satisfy the notice requirement if the employer has reasonable procedures with respect to determining compliance with the qualification rules and discovering failures to comply, the employer complies with such procedures, and the employer does not have actual knowledge of the failure.

In the case of a multiemployer plan, the rules described above apply, except that "multiemployer plan" is substituted for "employer".

Good faith compliance

The Tax Reform Act of 1986 directed the Secretary to issue guidance on certain employee benefit provisions added by the Act, including section 89. Under present law, until the Secretary issues guidance on which taxpayers may rely with respect to such provisions, an employer's compliance with its reasonable interpretation of the provision, based on the statute and its legislative history, if

made in good faith, constitutes compliance with the provision. The bill applies this good faith compliance standard to the provisions of the bill. This good faith standard applies, for example, to the rules relating to separate lines of business and the new definition of leased employee under the bill.

Except where directly inconsistent with the provisions of the bill, prior legislative history relating to any provision amended by the bill (including the rules of section 89) and guidance issued by the Secretary pursuant to any such provision, continue in effect.

Separate lines of business or operating units

The bill also provides that, with respect to lines of business that do not meet the guidance issued by the Secretary, the good faith standard applies to the determination of whether lines of business are separate under section 414(r)(2)(C) until the first plan year beginning after the Secretary issues guidance under section 414(r)(2)(C) and, with respect to lines of business that do not satisfy the Secretary's guidelines, until the first plan year beginning after the Secretary begins issuing rulings relating to lines of business.

As under present law, it is generally intended that a line of business or operating unit include all employees necessary for the preparation of property for sale to customers or for the provision of services to customers. Whether lines of business or operating units are separate is a facts and circumstances determination requiring examination of each particular situation. Differences and similarities between the services provided and products produced by claimed lines of business or operating units are among the factors to be considered.

It is intended that separate lines of business may be established under the reasonable good faith standard under certain circumstances, for example, in the case of operations that are vertically integrated and that traditionally are operated by unrelated entities. For example, a vertically integrated oil company may be able to treat its retail marketing operations as a line of business separate from its production and refining operations because the marketing of petroleum products is traditionally conducted by independent individual operators rather than by integrated companies.

Similarly, horizontally integrated businesses may be treated as maintaining separate lines of business where the employer produces different products (e.g., different types of agricultural crops) through separate business units. Of course, in all cases, the other requirements of the separate line of business rules must be satisfied (e.g., sec. 414(r)(2)).

Study

The Medicare Catastrophic Coverage Act of 1988 established the United States Bipartisan Commission on Comprehensive Health Care. The Commission was directed to report to Congress regarding long-term care benefits and health care benefits. The bill further directs the Commission to review the implementation and effectiveness of the section 89 nondiscrimination rules and to submit as part of its report recommendations for improving the effectiveness of section 89 in making employer-provided health insurance more accessible and affordable to low and middle income employees and

alternative methods for improving accessibility and affordability of health insurance available in the workplace.

Effective Date

The new discrimination rules relating to section 89 are generally effective for plan years beginning in 1990. The employer is permitted an election to use present law with respect to its plans for 1990 and 1991. This election relates to all plans of the employer and may be made on an annual basis. The employer may also elect to use present law to test its dependent care assistance programs under section 89 for 1990 and 1991. Whether or not the employer makes an election to use present law, the changes under the bill that relate to excluded and former employees apply. Further, the exception for multiemployer plans provided under the bill is effective without regard to any election.

Revenue Effect

These provisions are estimated to reduce fiscal year budget receipts by $20 million in 1989 and by $57 million in 1990.

C. Extension of the Telephone Excise Tax (Sec. 301 of the Bill)

Present Law

Excise tax rate

A 3-percent excise tax is imposed on amounts paid for local telephone service, toll telephone service and teletypewriter exchange service (sec. 4251). The tax is paid by the person who pays for service to the person rendering the service, who in turn remits the tax to the general fund of the Treasury.

Exemptions from the tax are provided for international organizations, the American National Red Cross, servicemen in combat zones, nonprofit hospitals and educational organizations, State and local governments, and certain communications services furnished to news services for use in collection of dissemination of news services (except local telephone service to news services). Other exemptions include amounts paid for installation charges and for certain calls from coin-operated telephones (sec. 4253). Under regulations, those claiming exemption are generally required to file annual exemption certificates (Treas. Reg. 49.4253-11).

This excise tax is scheduled to terminate, effective with respect to amounts paid pursuant to bills first rendered on or after January 1, 1991.

Deposit of telephone tax

General rule for excise taxes.—If a person has over $2,000 in excise tax liability for any month, semi-monthly deposits of the tax collected generally must be made by the 9th day following the end of the semi-monthly period.

Deposit rule for telephone excise tax.—Under present IRS rules (Rev. Proc. 76-45, 1976-2 C.B. 668; also Treas. Reg. 49.6302(c)-1), the telephone excise tax is considered as collected during the second semi-monthly period following the semi-monthly billing period. Such tax is then to be deposited within 3 banking days after the end of the semi-monthly period for which it is considered to be collected. For example, telephone tax billed by a telephone service provider to customers during the June 1-15 semi-monthly period is considered as collected during the July 1-15 semi-monthly period, with deposit of tax due within 3 banking days thereafter. The service provider makes quarterly adjustments in the tax billed and amounts collected.

Reasons for Change

The extension of the current 3-percent telephone excise tax will not further burden taxpayers as it is only an extension of an existing tax and it is easily administered. The extension of the tax will provide needed revenues to finance the bill's tax credit provisions relating to dependent care and child health insurance expenditures. The concurrent budget resolution for fiscal year 1990 provides that child care initiatives may be considered in a revenue-neutral context.

The change in the deposit schedule for the telephone excise tax provides for more timely transfer of the tax revenues to the Government.

Elimination of the requirement for certain exempt organizations to file annual exemption certificates will reduce the administrative burden of filing the exemption certificates.

Explanation of Provisions

Extension of tax

Under the bill, the 3-percent telephone excise tax is made permanent.

Deposit of tax

The bill provides that the telephone excise tax billed for a semi-monthly period is to be deposited within 3 banking days after the first week (7 days) following the next semi-monthly period. For example, telephone tax billed by the telephone service provider during the June 1-15 semi-monthly period will be required to be deposited within 3 banking days after July 7.

Exemption certificates

The bill provides that those communications service recipients exempt from the tax on communications services by reason of being a qualified international organization, nonprofit hospital, nonprofit educational organization, or a State or local government are relieved from having to file a certificate of exemption annually. Instead, the bill provides that such communications service recipients are granted a continuing exemption. However, should the service recipient no longer qualify for exemption or should the information on which the original exemption was based change, the service recipient must inform the service provider within 30 days.

Effective Dates

The extension of the telephone excise tax is effective on January 1, 1991. The change in the tax deposit requirements is effective for tax billed after August 15, 1990. The change in teh exemption certification requirement is generally effective for new exemptions claims made after the date of enactment; any existing annual exemption certificate remains in effect until the end of the annual period.

Revenue Effect

The permanent extension of the 3-percent telephone excise tax is estimated to increase net fiscal year budget receipts by $1,612 million in 1991, $2,732 million in 1992, $2,930 million in 1993, and $3,143 million in 1994.

The change in the telephone tax deposit requirements is estimated to increase net fiscal year budget receipts by $102 million in 1990, $7 million in 1991, $8 million in 1992 and 1993, and $9 million in 1994.

D. Estimated Tax Payment Requirements of S Corporations (Sec. 302 of the Bill)

Present Law

In general, an S corporation is not subject to tax on its taxable income. Rather, taxable income of an S corporation flows through to its shareholders in a manner similar to a partnership. However, there are limited instances when an S corporation is subject to tax. These instances include (1) the recognition of a built-in gain within 10 years of the date that a former C corporation elected S corporation status (sec. 1374(a)); (2) the receipt of passive investment income in excess of 25 percent of total annual gross receipts if the corporation has earnings and profits from a year in which it was not an S corporation (sec. 1375(a)); and (3) the recapture of investment tax credits claimed during a taxable year in which the corporation was not an S corporation (sec. 1371(d)).

Although situations exist for which an S corporation is liable for income tax, present law does not require the corporation to make estimated tax payments. Instead, the tax must be paid no later than the unextended due date of the S corporation tax return.

Reasons for Change

The items for which S corporations are subject to income tax are generally items for which C corporations are subject to income tax. Thus, S corporations should be generally subject to the estimated tax payment provisions for those items in the same manner as C corporations.

Explanation of Provision

The bill provides that an S corporation is required to make estimated tax payments if it has tax attributable to (1) the recognition of built-in gains under section 1374(a) [2] ; (2) the realization of excess passive income under section 1375(a); or (3) the recapture of investment tax credits by reason of section 1371(d). The rules contained in section 6655 for estimated tax payments by corporations generally apply.

The bill provides that, for purposes of estimated tax payments attributable to built-in gains and investment tax credit recapture, an S corporation would not be able to utilize the exceptions which allow estimated tax payments to be based on the corporation's prior year tax (secs. 6655(d)(1)(B)(ii) and 6655(d)(2)(B)). The prior year's tax exception is available to all S corporations (including "large" S corporations) with respect to required estimated tax payments attributable to excess passive income (to the extent the S corporation paid tax on excess passive income in the prior year). In all situations, an S corporation will be able to use the annualization exception (sec. 6655(e)).

---

[2] The bill also applies to tax that is attributable to certain capital gains of S corporations pursuant to section 1374 as effective before the changes made by the Tax Reform Act of 1986.

Effective Date

The provision is effective for estimated tax payments due after the date of enactment for taxable years ending after the date of enactment. For this purpose, tax relating to items that arose before the date of enactment (but during the taxable year that includes the date of enactment) will be taken into account ratably with respect to the estimated tax payments required after the date of enactment for such taxable year. In addition, for those S corporations that utilize the annualization exception for the required estimated tax payments for the taxable year that includes the effective date, the longer of the optional periods described in section 6655(e)(2)(A)(i) shall apply.

Revenue Effect

The provision is estimated to increase fiscal year budget receipts by $25 million in 1989 and less than $5 million annually in fiscal years 1990-94.

III. BUDGET EFFECTS

In compliance with paragraph 11(a) of Rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the estimated budget effects of the bill, as reported by the committee.

The table below presents the estimated budget effects of the provisions of the bill, as reported by the committee, for fiscal years 1989–1994.

ESTIMATED REVENUE EFFECTS OF TAX PROPOSALS, FISCAL YEARS 1989–94

[In millions of dollars]

Item	1989	1990	1991	1992	1993	1994	1989–94
A. Tax credit for child care and child health insurance:							
1. make child/dependent care credit refundable and increase credit for AGI less than $10,000:							
a. Fiscal year totals		−25	−565	−1,763	−1,832	−2,000	−6,185
b. Fiscal year outlays (refundable portion)			−559	−1,745	−1,814	−1,980	−6,098
2. Child health insurance credit (50 percent)							
a. Fiscal year totals			−70	−1,473	−1,385	−1,368	−4,296
b. Fiscal year outlays (refundable portion)				−1,163	−1,153	−1,200	−3,516
B. 1-year delay and simplification of sec. 89 nondiscrimination rules	−20	−57					−77
C. Telephone excise tax:							
1. Permanent extension			1,612	2,732	2,930	3,143	10,417
2. Modification of collection period		102	7	8	8	9	134
D. Require estimated tax payments on tax liability for certain subchapter S income	25	(1)	(1)	(1)	(1)	(1)	25
Grand total	5	20	984	−496	−279	−216	18
Total outlays (refundable portion of child care and health insurance credits)			−559	−2,908	−2,967	−3,180	−9,614

[1] Gain of less than $5,000,000

IV. REGULATORY IMPACT AND OTHER MATTERS TO BE DISCUSSED UNDER SENATE RULES

A. Regulatory Impact

Pursuant to paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate, the committee makes the following statement concerning the regulatory impact that might be incurred in carrying out the bill as reported.

Impact on individuals and businesses

The bill makes several changes in existing tax provisions. The bill makes the present-law dependent care tax credit refundable for certain taxpayers, increases and modifies the dependent care credit for certain taxpayers, and allows an additional tax credit for certain health insurance expenditures.

The bill adopts the provisions of S. 1129, with amendments, relating to simplification of section 89 nondiscrimination rules applicable to certain employee benefit plans, and delays for one year (until 1990) the application of the section 89 rules.

In order to report a revenue neutral bill, the committee included a permanent extension of the existing 3-percent telephone excise tax, currently scheduled to expire after December 31, 1990. The bill also includes a speedup of the deposit requirement for the telephone tax. Further, the bill provides than an S corporation is required to make estimated tax payments in certain circumstances.

Impact on personal privacy

The bill generally does not affect taxpayer personal privacy.

Impact on paperwork

The bill will simplify the application of the section 89 nondiscrimination rules with respect to employee benefit plans. The bill provides special rules for small business employers and for full and part-time employees.

The bill adds a tax credit for certain health care expenditures and makes the dependent care credit refundable. For taxable years beginning after 1991, the dependent care and health insurance credits will be refundable on an advance payment basis (similar to the present-law earned income credit).

The bill will require S corporations to make estimated tax payments in certain circumstances.

B. Other Matters

Vote of the Committee

In compliance with paragraph 7(c) of Rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the vote of the committee on the motion to report the provisions of the bill. The provisions of the bill were ordered favorably reported by a roll call vote of 17 ayes and 3 noes.

Consultation with Congressional Budget Office

Budget estimates.—In accordance with section 403 of the Budget Act, the committee advises that the Congressional Budget Office has not submitted a written statement as of the time the report was filed.

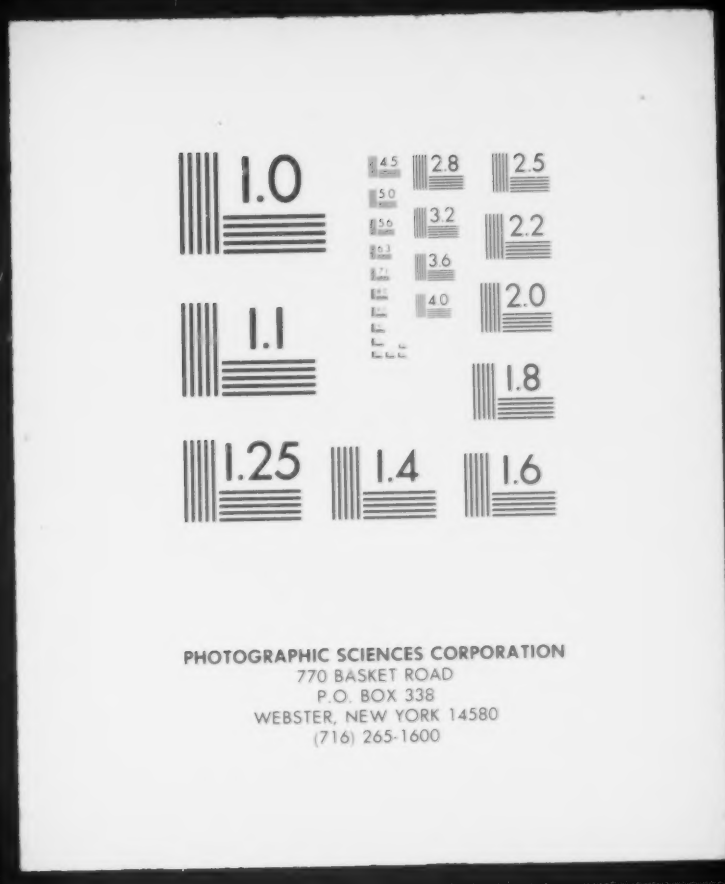
Budget authority.—In compliance with section 308(a)(1) of the Budget Act, the committee states that the refundable portion of the dependent care and health insurance tax credits will increase budget authority and outlays by $9,614 million over the period, fiscal years 1991-1994. There is no impact on budget authority or outlays in fiscal year 1990.

Tax expenditures.—In compliance with section 308(a)(2) of the Budget Act, the committee states that the bill involves new tax expenditures for the new health insurance tax credit and increased tax expenditures for the modified dependent care credit and the delay and revision of the section 89 rules. (See Part III for the specific estimates for these items.)

V. CHANGES IN EXISTING LAW MADE BY THE BILL

In the opinion of the committee, it is necessary in order to expedite the business of the Senate to dispense with the requirements of paragraph 12 of Rule XXVI of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the provisions of the bill as reported by the committee).

○



20:1

Compilation © 1989 Congressional Information Service
All rights reserved.